



UNITED STATES ENVIRONMENTAL PROTECTION AGENCY

REGION 4
ATLANTA FEDERAL CENTER
61 FORSYTH STREET
ATLANTA, GEORGIA 30303-8960

OCT 20 2016

UNITED PARCEL SERVICE

Mr. Steven P. Solow, Esq.
Katten Muchin Rosenman LLP
2900 K Street NW
Washington, DC 20007-5118

Re: Chevron USA, Inc., Pascagoula, Mississippi
Notice of General Duty Clause and Risk Management Program Violations

Dear Mr. Solow:

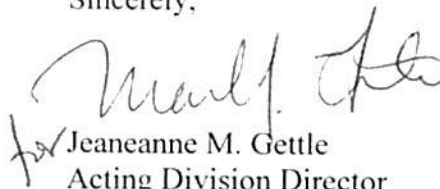
The purpose of this letter is to provide your client with notice of potential violations of the Clean Air Act ("CAA") General Duty Clause ("GDC"), 42 U.S.C. § 7412(r)(1), and Risk Management Program ("RMP"), 42 U.S.C. § 7412(r)(7), at the Chevron USA, Inc. ("Chevron") Petroleum Refinery in Pascagoula, Mississippi. Potential violations were identified based on responses to the EPA's August 25, 2014, CAA § 114 information request and the EPA's September 8-11, 2014 inspection, at Chevron's Pascagoula Refinery.

The General Duty Clause allegations stem from the November 15, 2013, incident at the Chevron Pascagoula Refinery. The United States Environmental Protection Agency, Region 4 has determined that Chevron potentially violated the first two prongs of the GDC which require the owner or operator of a facility that produces, processes, handles, or stores extremely hazardous substances to 1) identify hazards and 2) design and maintain a safe facility. The RMP potential violations stem from deficiencies in Chevron Pascagoula Refinery's program level 3 processes and Chevron's failure to identify flares as a program level 1 process at the Chevron Pascagoula Refinery. The specific potential violations are identified below in the confidential attachment.

The EPA looks forward to the opportunity to meet with Chevron to discuss these potential violations. During the meeting, the EPA expects Chevron to present any factual information or other evidence relative to this matter, including information that Chevron believes refutes the violations or information which shows that Chevron has returned to compliance.

It is our hope that we can resolve this matter without need of litigation. Thank you very much for your prompt attention to this important matter.

Sincerely,



Jeanne M. Gettle
Acting Division Director
Air, Pesticides and Toxics Management Division

Enclosure

Chevron NOV Attachment

General Duty Clause Potential Violations

1. Failure to identify hazards.

Chevron conducted a re-evaluation of its hazard assessment for the Plant 80 Continuous Catalytic Reformer Reformat (CCR) Splitter process in January 2012. This re-evaluation did not consider hazards from known bogging events that happened during startup of the F-8007 fired heater. According to the Center for Chemical Process Safety's "*Guidelines for Hazard Evaluation Procedures*", "before the hazard evaluation actually begins, the participants should review previous incidents involving the process to be studied. This review of incidents should include all types of incidents involved in the process, including personnel injuries and near misses, for at least the previous five years."

The January 2012 re-evaluation of the hazard assessment did not address the hazards associated with bogging events that occurred at the F-8007 fired heater at the Pascagoula Refinery on January 21, 2011; February 22, 2011; and December 30, 2011. While Chevron conducted an incident investigation of the February 22, 2011, bogging event, Chevron did not analyze the bogging hazard in its re-evaluation of the hazard assessment to determine what changes should be made to address this hazard.

2. Failure to design and maintain a safe facility.

- a. Failure to develop and implement sufficient operating procedures for *Furnace Dry Out* (080-NP-4402), *Furnace Startup* (080-NP-4401), and *Setting Minimum Flow at Furnace* (080-JA-4401).

Chevron's Operating Procedure for the *Furnace Dry Out* did not warn that a bogging event is a potential explosive condition. Insufficient air for complete combustion is a bogging situation. The *American Petroleum Institute's Recommended Practice 556, Instrumentation, Control, and Protective Systems for Gas Fired Heaters* (API Recommended Practice 556) identifies the hazard of bogging. API Recommended Practice 556 also identifies the potential hazardous event of "explosion" which may result from improper air/fuel control (insufficient air for complete combustion). Bogging was not mentioned as a possible hazard in the *Furnace Dry Out* Operating Procedure.

Chevron's Operating Procedures for the *Furnace Startup* process were inadequate because the procedures failed to properly warn about the potential explosion hazard that could occur when a fired heater becomes bogged. Although the *Furnace Startup* Operating Procedure did contain a boxed warning addressing bogging, this boxed warning was inconsistent with API Recommended Practice 556 that identifies the potential hazard as "an explosion." The boxed warning in the procedure only identified the potential hazard as a "dangerous situation."

The process for *Setting a Minimum Flow at Furnace* should have been governed by an operating procedure rather than a job aid. According to Chevron's RI-113 Operating Procedures/Electronic

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Operations Manual, written operating procedures, rather than job aids should be utilized for “Critical” or “Difficult” tasks. Chevron’s internal definition of “Critical”, as defined in its Operating Procedures/Electronic Operations Manual is:

Critical Task

- a. Task could result in person injury and is not a routine duty or task
- b. Task could result in equipment damage and is not a routine duty or task.
- c. Task could result in environmental release and is not a routine duty or task.

The procedure to set minimum flow for the F-8007 furnace meets Chevron’s own definition of a “Critical Task” as it involves the addition of flammable gas to the heater. As was demonstrated by the November 2013 incident, if not performed properly, the addition of gas to the heater could result in an explosive situation resulting in personal injury, equipment damage, and an environmental release. Moreover, this procedure is not routine, as it is only performed a few times a year. Even if a Job Aid were considered to be sufficient for setting a minimum flow at furnaces, Chevron’s job aid was inadequate as it did not warn that bogging was a potential hazard that could occur while setting the minimum temperature.

Finally, neither the *Furnace Dry Out* Operating Procedure, the *Furnace Startup* Operating Procedure, nor the *Setting a Minimum Flow at Furnace* Job Aid warned about huffing, and the procedures did not provide instructions for how to handle a huffing situation.

- b. Failure to properly train its operators on fired heaters.

Only three of the eight fired heater operators completed the Fired Heater specific training, *GMOC/P/GFOTPI Web based Module – Fired Heaters*. Only one of three fired heater operators who completed Fired Heater specific training completed refresher training on the subject.

- c. Failure to conduct appropriate emergency response planning for fired heater burner lighter operations.

The *Process Pre-Incident Plan* for the Plant 80/Reformate Splitter Unit did not mention a bogging or huffing event associated with the furnace as a potential emergency. Chevron’s *Process Pre-Incident Plan* only provided technical information (equipment), target hazards, and water requirements for the CCR process. The plan did not provide steps for mitigation of any potential emergencies listed for the CCR area. Ultimately, none of the procedures reviewed for the F-8007 furnace operation developed prior to the November 15, 2013 accident specified that employees need to evacuate the area when the fired heater becomes bogged or experienced huffing.

Risk Management Program Potential Violations

1. **Failure to include in the process safety information, updated information pertaining to piping and instrument diagrams (P&IDs) for the Blending Tankfield and Wastewater Treatment process as required by 40 CFR § 68.65(d)(1)(ii).**

Based on field observation conducted by the Region 4 inspection team in September 2014, the T-282 P&ID for the Blending Tank-field (Drawing # 34-KF-59187-002, revision 14, CUSA-PAS-EPA-001850) was not accurate. The P&ID indicated a local pressure indicator PI 1801 should be in place. However, this pressure indicator was not observed in the field. The P&ID indicated vacuum breaker PRD 9869 should be set at 2.5 psia. However, the tag on PRD 9869 observed in the field indicated PRD 9869 was set at 6.7 psi vacuum (8 psia). The P&ID indicated local pressure indicator PI 1805 should have a flange upstream of it. However, there were three manual valves rather than a flange upstream of PI 1805. Labels on the temperature elements, TE 1799 and TE 1797 also were not identified in the field.

In addition, the T-271 and T-270 LPG Operating Storage P&ID for the Blending Tank-field was not accurate. The P&ID indicated PRD 9588 was located downstream of the branch of P4321-6"-N with P4820-8"-N, but the PRD was located upstream of the branch. The P&ID indicated both T-270 and T-271 had the same temperature indicator, TI-8111, but the temperature indicator on T-271 was TI-8112, as opposed to TI-8111. The P&ID indicated both T-270 and T-271 had the same level alarm, LA-5160; local pressure indicator, PI-6178; and pressure alarm, PA-5152. Both T-270 and T-271 should have their own level alarm, local pressure indicator, and pressure alarm on the P&ID. The inspection team observed in the field a local pressure indicator that was not labelled. The P&ID did not include an instrumented temperature element, 34-TE-0361, that was present in the field. The P&ID indicated a local pressure indicator on line P4321-6"-N, downstream of AOV 1047 that was not observed in the field. The P&ID indicated AOV 1047 is an 8"x 6" valve. However, in the field AOV 1047 was observed to be an 8" valve and there was a separate 8"x 6" valve upstream of AOV 1047 that was not indicated in the P&ID.

Moreover, based on field verification, the D-9520 Ammonia Storage Tank P&ID (Drawing # 95-KF-56244-001, revision 17, CUSA-PAS-EPA-001847) was not accurate. The inspection team observed valves on the level gauge lines at the bottom of the tank that were not indicated on the P&ID. The manual valves upstream of PRD 3020 and PRD 3019 were observed in the field to be locked open. However, the P&ID did not indicate these valves were to be locked open.

2. Failure to update and revalidate Process Hazard Analyses (PHA) at least every five years after the completion of the initial process hazard analysis as required by 40 CFR § 68.67(f).

Chevron failed to include completion dates for PHAs to indicate that each PHA had been updated every five years. Chevron provided a spreadsheet containing historical PHA dates for plants and units as early as 1997. Only a single date was provided for each PHA. According to a note on the schedule, PHA dates listed in the schedule for 2002 and onward are the start date of the PHA. PHA dates prior to 2002 are the end date of the PHA study. PHAs for 2002 and onward are not adequately documented to demonstrate the PHAs were conducted on a 5-year schedule. The spreadsheet does not provide the PHA completion date, the PHA recommendation report out meeting date, the PHA study publication date, or any other event that could signify the completion of the PHA study. Thus, PHAs may be started prior to the 5-year anniversary date, but this does not guarantee that the PHA for the process has been updated at least every 5 years.

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3. Failure to submit a single Risk Management Plan (RMPlan) for its flares process as required by 40 CFR § 68.150.

Chevron failed to account for all phases of the flammable mixture associated with flare(s), which would have set the flares process over the 10,000 pound threshold to be reported in their RMPlan.